Delta Dental of Illinois Enrollment/Change of Status Form for Dental and Vision Policy

PLEASE SEND APPLICATION TO ATTENTION: AFFINITY DEPARTMENT
P.O. BOX 3930 | PEORIA, IL 61612-9806 OR FAX: 866-817-9009

Please type or print in black ink and complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

APPLICANT

Last Name	First Name	Middle Initial	Date of Birth
			___/___/_____

Gender	Marital Status	Social Security Number
☐ Male ☐ Female	☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Civil Union ☐ Domestic Partnership	

Applicant Status ☐ Member of Association and/or Member of Trust ☐ Other _____

Mailing Address	City	State	ZIP

Phone Number	Email Address
( )	

Name of Association	Association Number	Sublocation Number
AVMA LIFE	20363	(if applicable)

Requested Effective Date of Coverage	
___/___/_____	

I consent to receive Explanation of Benefits (EOBs) from Delta Dental of Illinois by Email. ☐ Yes ☐ No

I consent to receive policy and legally required communications from Delta Dental of Illinois by Email. ☐ Yes ☐ No

APPLICANT/ DEPENDENT/ ADDITIONS/ TERMINATIONS/ CHANGES

Please check two of the options below.

☐ **Yes,** I want to enroll in the AVMA LIFE dental benefit plan offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

- ☐ Delta Dental PPO/Delta Dental Premier – High Plan
- ☐ Delta Dental PPO/Delta Dental Premier – Low Plan

☐ **No,** I do not want to enroll in the AVMA LIFE dental benefit plan offered by Delta Dental of Illinois.

☐ **Yes,** I want to enroll in the AVMA LIFE DeltaVision®* Coverage.

☐ **No,** I do not want to enroll in the AVMA LIFE DeltaVision Coverage.

CONTINUED ON NEXT PAGE

REASON(S) FOR SUBMITTING THIS FORM

☐ **Initial or Open Enrollment**

☐ **Retiree**

☐ **Reinstatement due to:**
☐ Loss of Other Coverage ☐ Other _____

☐ **Add Dependent due to:**
☐ Birth ☐ Adoption/Placement for Adoption ☐ Marriage ☐ Domestic Partnership
☐ Civil Union ☐ Legal Guardianship ☐ Loss of Other Coverage
☐ Dependent Child with Disability ☐ Military Dependent ☐ Court Order ☐ Other _____
Date of Qualifying Event ___/___/_____

☐ **Drop Dependent due to:**
☐ Age ☐ Death ☐ Divorce ☐ Other Coverage Elsewhere
Date of Qualifying Event ___/___/_____

☐ **Name Change**
Former Name _____ New Name _____

☐ **Address Change** _____

☐ **Termination of Employment**
Date ___/___/_____

ENROLLMENT SELECTION

Select one for dental:

☐ **Applicant Only**	☐ **Applicant Plus One Dependent Child**
☐ **Applicant Plus Spouse or Domestic Partner**	☐ **Entire Family**

Is your spouse covered under another dental plan? ☐ Yes ☐ No
If "**Yes**," list the name of the carrier: _____
Please list your spouse's employer: _____

Are you and/or your dependent(s) covered by any other dental benefit program? ☐ Yes ☐ No
If "**Yes**," list the name of the carrier: _____

Select one for DeltaVision:

☐ **Applicant Only**	☐ **Applicant Plus Child(ren)**
☐ **Applicant Plus Spouse or Domestic Partner**	☐ **Entire Family**

CONTINUED ON NEXT PAGE

DEPENDENTS

Indicate the names of all dependents to be insured or terminated under the AVMA LIFE Policy.

Add	Delete	First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Dependent Status	Gender
				___/___/____		☐ Military ☐ Disabled	☐ Male ☐ Female
				___/___/____		☐ Military ☐ Disabled	☐ Male ☐ Female
				___/___/____		☐ Military ☐ Disabled	☐ Male ☐ Female
				___/___/____		☐ Military ☐ Disabled	☐ Male ☐ Female

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

DISCLAIMER: The Spanish version of this form is provided only as a courtesy to the customer. The English version of this form will be the presiding version in any case of a dispute or complaint.

DESCARGO DE RESPONSABILIDAD: La versión en español de este documento se proporciona únicamente como cortesía para el cliente. La versión en inglés de este documento constituirá la versión predominante en el caso de alguna disputa o reclamación.

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits.

Signature of Applicant	**Date** ___/___/_____

**DeltaVision is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.*

AVMA LIFE® AVMA PLIT®
Veterinarian Inspired Coverage Protecting you through it all

Billing Information

Bill Recipient ☐ Applicant ☐ Employer (please complete section below)

Clinic Name

Clinic Address

Contact Name

Contact Phone

Contact Email

AVMA LIFE Agent Section
(To be completed by the writing agent)

Name of Agent

Date